Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
512-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address

Respondent Name
AMERICAN HOME ASSURANCE CO

Carrier's Austin Representative Box
Box Number 19

MFDR Tracking Number
M4-13-1627-01

MFDR Date Received
January 10, 2013

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: The requestor did not submit a position summary,

Amount in Dispute: $618.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "This request should not be eligible for review by MFDR. The requestor is identified as the claimant. The claimant may only act as the requestor per Rule 133.307(b)(3) or (4). This is not the case here. Per Rule 133.307(c)(1)(A) disputes must be filed within one year after the DOS is dispute. That would exclude DOS 5/18/10 and 1/5/12. There is no indication that the requestor submitted a request for reconsideration prior to filing for medical dispute resolution. The carrier has not record of receiving bills for DOS 5/24/12 or 8/23/12. "

Response Submitted by: Flahive, Ogden & Latson, PO Box 201320, Austin, TX 78720

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
May 18, 2010 January 5, 2012	Office Visits and other procedures UNTIMLEY FILED	$382.00	$0.00
May 24, 2012 August 23, 2012	Office Visits TIMELY FILED	$236.00	$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. The services in dispute were reduced/denied by the respondent with the following reason codes:

   Explanation of benefits was not submitted by either party.

Issues

1. Did the requestor submit the request for medical fee dispute resolution in a timely manner?
2. Did the requestor pay out-of-pocket for the services in dispute?
3. Is the requestor entitled to reimbursement?

Findings

1. In accordance with 28 Texas Administrative Code §133.307, a requestor shall timely file the request with the division's MFDR Section or waive the right to MFDR. According to §133.307 (c), a request for MFDR shall be filed no later than one year after the date(s) of service in dispute. Review of requests of documentation provided finds that dates of service in dispute are May 18, 2010 through August 23, 2012. Based on the date that this medical fee dispute was received in MFDR (January 10, 2013), the division concludes that:
    - dates of service May 18, 2010 and January 5, 2012 were not submitted timely to MFDR; therefore the requestor has waived its right to medical fee dispute resolution for these dates; and
    - dates of service May 24, 2012 and August 23, 2012 were submitted timely; therefore these dates shall be reviewed in accordance with the applicable Texas Labor Code provisions and applicable rules.
2. In accordance with 28 Texas Administrative Code §133.307(c)(4) an injured employee who has paid for health care may request MFDR of a refund or reimbursement request that has been denied. The injured employee's dispute request shall be sent to the MFDR Section in the form and manner prescribed by the division by mail service, personal delivery or facsimile and shall include: (E) the amount paid by the injured employee; (F) the amount of the medical fee in dispute; (G) an explanation of why the disputed amount should be refunded or reimbursed, and how the submitted documentation supports the explanation for each disputed amount; (H)proof of employee payment (including copies of receipts, health care provider billing statements, or similar documents); and (I) a copy of the insurance carrier's or health care provider's denial of reimbursement or refund relevant to the dispute, or, if no denial was received, convincing evidence of the injured employee's attempt to obtain reimbursement or refund from the insurance carrier or health care provider. Review of the submitted documentation finds that the requestor did not submit receipts showing the requestor paid for the services in dispute. On March 6, 2013, MFDR contacted the injured employee requesting receipts for dates of service May 24, 2012 and August 23, 2012, showing the injured employee had paid for the services in dispute. At this time it was discovered that the injured employee had not incurred out-of-pocket expenses and was just trying to get the doctor paid.
3. The requestor has not supported that out-of-pocket expenses were incurred; therefore, the requestor is not entitled to reimbursement.

Conclusion

For the reasons stated above, the Division finds that the requestor has not established that additional reimbursement is due. As a result, the amount ordered is $0.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to $0.00 reimbursement for the disputed services.

Authorized Signature

Signature	Medical Fee Dispute Resolution Officer	September 16, 2013 Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, effective May 31, 2012, *37 Texas Register 3833*, **applicable to disputes filed on or after June 1, 2012**.

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.